

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
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NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
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S000000	<p>This visit was for a followup to the State hospital licensure survey that was conducted on 1/8/2014 through 1/9/2014.</p> <p>Dates: 3/12/2014 through 3/13/2014</p> <p>Facility Number: 004975</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Jennifer Hembree, RN PH Nurse Surveyor</p> <p>Nine previously cited deficiencies were found corrected and six uncorrected deficiencies were recited.</p>	S000000		
S000308	<p>QA: cloughlin 03/31/14 410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on document review and staff interview, the facility failed to job specific orientation for one (1) manager (staff #F). Findings include;1. Staff member #F personnel file lacked evidence of department specific orientation. He/she was hired 1/7/14. 2. Staff member #3 verified in interview beginning at 3:10 p.m. on 3/13/14 there was no dietary orientation documents for staff member #F.	S000308	ISDH PLAN OF CORRECTION STATE TAG ID: S 308 DATE DEFICIENCY WILL BE CORRECTED: 4/9/2014 WHO IS RESPONSIBLE: DEPARTMENT MANAGERS AND DOUG LEE, MANAGER OF HUMAN RESOURCES WHAT IS THE PLAN OF CORRECTION: EACH DEPARTMENT WILL HAVE A DEPARTMENT SPECIFIC ORIENTATION CHECKLIST FOR NEW EMPLOYEES. WHEN THE PLAN OF CORRECTION WILL BEGIN: 4/09/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: EACH DEPARTMENT MANAGER WILL LOCATE AND UPDATE OR DEVELOP, AND IMPLEMENT A DEPARTMENT SPECIFIC ORIENTATION CHECKLIST TO BE DONE BY THE PRECEPTOR OF THE NEW EMPLOYEE CONTAINING SPECIFIC ELEMENTS OF PERFORMANCE IN THAT DEPARTMENT IN ORDER TO VALIDATE COMPETENCY IN THE POSITION. EACH ELEMENT OF PERFORMANCE TAUGHT DURING THIS ORIENTATION SHOULD BE SPECIFIC, AND INITIALED BY THE PRECEPTOR OF THE NEW EMPLOYEE UPON DEMONSTRATED COMPETENCY OF EACH ELEMENT, AND THE ENTIRE COMPLETED CHECKLIST SHOULD BE SIGNED BY THE EMPLOYEE RECEIVING THE	04/09/2014	

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S000602	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(vi)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(vi) An isolation system.</p> <p>Based on document review and staff interview the facility failed to follow the isolation precautions policy for 1 patient (patient #6) on the behavioral health unit (BHU). Findings include;1. Facility policy titled "Isolation Precautions" last reviewed/revised 6/13 states on page 3 under</p>	S000602	<p>TRAINING, THE PRECEPTOR, AND THE DEPARTMENT MANAGER. THE COMPLETED CHECKLIST WILL THEN BE FORWARDED TO THE MANAGER OF HUMAN RESOURCES TO BE FILED AND MAINTAINED IN THE EMPLOYEE FILE.</p> <p>ISDH PLAN OF CORRECTION</p> <p>STATE TAG ID: S0602</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 4/16/2014</p>	04/16/2014			

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	<p>Contact Precautions: "Used in addition to Standard Precautions for patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with patient..... Examples of such conditions include:.....MRSA." Under patient care, the document indicates care will include, but is not limited to, patients out of room for essential purposes only...." 2. Review of patient #6 medical record indicated he/she had MRSA to a wound. 3. Staff member #172 indicated the following in interviews beginning at 1:40 a.m. on 3/12/14: (A) Isolation patients are among general population depending on who you work with. Certain staff will keep patients in their rooms while others will allow them to be out. Patient #6 had an infection and some days was allowed out of room while others he/she was told to keep the patient in their room.</p>		<p>WHAT IS THE PLAN OF CORRECTION: THE POLICY PERTAINING TO ISOLATION OF COMMUNICABLE DISEASES WAS REVIEWED AND UPDATED TO INCLUDE THE ABILITY FOR A PATIENT TO BE OUT OF THEIR ROOM AS LONG AS THE SOURCE OF THE ORGANISM BEING ISOLATED WAS CONTAINED. THIS WOULD INCLUDE, BUT IS NOT LIMITED TO, WOUND DRESSINGS FOR INFECTED WOUNDS OR FOLEY CATHETER FOR URINE INFECTIONS. THIS HAS ALWAYS BEEN THE PRACTICE AT SAINT CATHERINE REGIONAL HOSPITAL, HOWEVER, OUR POLICY DID NOT REFLECT IT.</p> <p>WHO IS RESPONSIBLE: GINGER OTTERSBAACH RN, CNO; KIMMIE C PERRA RN, QUALITY DIRECTOR/NURSING EDUCATION/IP; BETH FISHER RN, BHS/MS DIRECTOR</p> <p>WHEN THE PLAN OF</p>	

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			<p>CORRECTION WILL BEGIN: 4/16/2014</p> <p>HOW THE DEFICIENCY REOCCURANCE WILL BE PREVENTED: ISOLATION PRECAUTIONS AND THEIR PRACTICAL IMPLEMENTATION ON EACH OF THE UNITS AT SAINT CATHERINE REGIONAL HOSPITAL WILL BE INCLUDED IN CLINICAL ORIENTATION AT THE BEGINNING OF EMPLOYMENT AND THEN ANNUALLY WITH THE YEARLY SKILLS CHECK-OFFS FOR CLINICAL STAFF. STAFF INSERVICING ON A 1:1 BASIS WILL BE PROVIDED ON A "AS NEEDED" BASIS. THIS EDUCATION WILL INCLUDE THE RESPONSIBILITY OF ALL STAFF TO MONITOR ONGOING COMPLIANCE AND ADHEREANCE TO THE ISOLATION POLICY AND THE NEED TO REPORT TO THEIR SUPERVISOR ANY AREAS OF IMPROVEMENT THAT THEY OBSERVE.</p> <p>THE FOLLOWING IS A COPY OF THE POLICY REVIEWED/REVISED: 4/14 POLICY: Isolation Precautions guidelines as revised by CDC (Center for Disease</p>		

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			Control and Prevention) and HICPAC (Hospital Infection Control Practices Advisory Committee) will be used for the prevention of transmission of infections. These guidelines include "Standard Precautions", which apply to the care of all patients, regardless of their diagnosis, and "Transmission Based Precautions" which are designed for patients, which are known or suspected to be infectious. PROCEDURE: GUIDELINES STANDARD PRECAUTIONS Standard Precautions is the foundation of all precautions to prevent transmission of infectious agents associated with healthcare because infectious agents may be present in blood and in all body fluids (except sweat), and on non-intact skin and mucous membranes of all patients; therefore hand hygiene and personal protective equipment (PPE), should always be used if contact with those fluids is likely and will be applied in the care of all patients regardless of their diagnosis or presumed infectious status. <u>Patient-Care</u> _ 1. Wash hands before and after patient care, regardless whether gloves are worn. It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross contamination of different body sites. If the hands are not visibly soiled they may be	

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			decontaminated with alcohol based hand gel. 2. Wear gloves when touching blood, body fluids, secretions and excretions, mucous membranes, non-intact skin, and contaminated items. 3. PPE is designed to prevent disease transmission among patients and healthcare workers, therefore, it is important to think of PPE as a universal means of preventing and controlling disease transmission. Wear PPE (personal protective equipment), including mask, eye protection and gown during procedures and patient care activities that are likely to generate splashes or sprays of blood and body fluids. Remove soiled gowns as quickly as possible and wash hands, in order to prevent transfer to other patients and environments. 4. Take care to prevent injuries when using needles, scalpels and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments; and when disposing of used needles. Do not recap used needles. 5. Use mouthpieces, resuscitation bags, or other ventilation devices as alternatives to mouth-to-mouth resuscitation. 6. Handle used patient care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing and transfer of		

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			<p>microorganisms to other patients and environments. Ensure that reusable equipment is not used for the care of another patient until it has been appropriately cleaned and reprocessed. 7. Single use items will be discarded and not reused. 8. Soiled linen will be handled in such a way to avoid transfer microorganisms to other patients, personnel and environment. They will be placed in a leak-proof bag and then they will be placed inside the lined container in the Dirty Utility that is designated for linen. All linen is considered contaminated and will be treated as such. Linen will then be picked up by Housekeeping.</p> <p>TRANSMISSION-BASED PRECAUTIONS Transmission based precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed. These include: A. Airborne Precautions Used in addition to Standard Precautions for patient known or suspected to be infected by organisms transmitted by airborne droplet nuclei (small particle residues 5 micron or smaller in size, of evaporated droplets containing microorganisms that remain suspended in the air and can be widely dispersed by air currents</p>	

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			<p>within a room or over a long distance). Examples of such illness include: · Measles · Varicella (including disseminated zoster) · Pulmonary Tuberculosis · Avian Influenza (Patients with a history of travel within 10 days to a country with Avian influenza activity and are hospitalized with a severe febrile respiratory illness, or are otherwise under evaluation for Avian influenza). <u>Patient Care</u></p> <ul style="list-style-type: none"> · The patient will be placed in a private negative-pressure room. · The doors to the room will remain closed and the patient will remain in the room. · Patients will be out of his/her room for essential purposes only and will wear an surgical mask while out of the negative pressure room. · N-95 Respirator masks will be worn to enter the room of patients with known or suspected AFB Disease and for susceptible persons who must enter the room of a patient with measles (rubella) or varicella (chicken pox). · (Susceptible persons should not enter the room of patients with known or suspected measles or varicella if immune caregivers are available). · All Staff members must complete fit testing for the N-95 respirator prior to entering negative pressure room with patient in Airborne Precautions. <p>B. Droplet Precautions Used in addition to Standard Precautions for a patient known or suspected to be infected by</p>	

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			<p>microorganisms transmitted by droplets (5 micron or larger in size) that can be generated by the patient during coughing, sneezing, talking, or the performance of other procedures. Examples of such illnesses include: · Meningitis · Influenza (Non-Avian suspected) · Pertussi · Respiratory MRSA <u>Patient Care</u> · If available, the patient will be placed in a private room. If not available, cohort with patients who have active infection with the same organism but with no other- infection. Maintain spatial separation of at least 3 feet from other patients and visitors if cohorting or private room is not available. · A surgical mask is required when working within three feet of patient. · Patient will be out of his/her room for essential purposes only and will wear a surgical mask while out of his/her room. · The patient's door may remain open. C. Contact Precautions Used in addition to Standard Precautions for patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient care activities that require touching the patient's dry skin) or indirect contact (touching) with environmental surfaces or patient care items in</p>	

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			<p>the patient's environment. Examples of such conditions include:</p> <ul style="list-style-type: none"> · Decubitis/wounds that are known to be infected. · All draining wounds. · C. diff infections of stool. · Hepatitis A in diapered or incontinent patients. · Scabies. · MRSA. · VRE. <p><u>Patient Care</u> · If available, the patient will be placed in a private room. If not available, cohort with patients who have active infection with the same organism but with no other infection. If this is not possible, contact the Infection Control Nurse for advice before patient placement.</p> <ul style="list-style-type: none"> · Wear gloves when entering room. Change gloves after contact with infective material. Remove gloves before leaving the patient's room. · Hands will be washed immediately with antimicrobial agent before leaving the patient's room. After glove removal and hand washing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the patient's room to avoid transfer of microorganism to other patients or environments. If hands are not visibly soiled, they may be decontaminated with alcohol based gel. · A gown will be worn if it is anticipated that clothes will have contact with the patient, environmental surfaces of the patient's room, or if the patient has any of the following: Incontinence Colostomy 	

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			<p>Diarrhea Ileostomy Wound Drainage not contained by a dressing · Gowns will be removed before leaving the patient's environment. · Patients will be out of his/her room for essential purposes only. During transport, ensure that all precautions are maintained at all times to minimize the risk of transmission of microorganisms. · When possible, dedicate the use of non-critical patient-care equipment for each patient. · If wound drainage contain patient may be out of room. See Appendix A for specific CDC Isolation Guidelines. 1. A physician's order should be written for Isolation Precautions. (Using Appendix A, determine the type of isolation precautions that are necessary). The nursing Supervisor or Infection Control Nurse may institute isolation precautions if the physician is not immediately available. 2. The Infection Control Nurse will be notified of any reportable communicable disease or conditions. 3. Proper Signage will be placed on the patient door. 4. Nursing will explain the need for Isolation Precautions to the patient, family and visitors and given the Isolation Education Sheet. (See attachment B). If there are further questions, the Infection Control Nurse will be notified to speak with the patient. This will be documented in the nurse's notes.</p>		

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			<p>5. When Isolation Precautions are discontinued, CNA will restock cart</p> <p>6. When Isolation Precautions are discontinued, disposable items will be discarded. Articles that are contaminated or likely contaminated and require special cleaning will be red bagged, labeled and placed in the dirty utility room. CSR will be notified to retrieve these items.</p> <p>7. Rooms of patients that were in Airborne Precautions and had a confirmed diagnosis, will remain closed for 90 minutes before terminal cleaning can be done by environmental services.</p> <p>8. When transporting an isolated patient to another department follow CDC Isolation Guidelines:</p> <ul style="list-style-type: none"> · Obtain the equipment necessary for transfer: Clean Sheet Stretcher or wheel chair Surgical mask (if patient is in Airborne or Droplet Precautions) · Inform the patient and/or significant other of need for transfer. · Notify receiving department that patient is in isolation for a specific disease. · Don the appropriate apparel to enter the room of the patient. · Cover the vehicle to be used for transport with a dry clean sheet. Transfer the patient to the vehicle and wrap the patient with the sheet. If the patient is in Airborne or Droplet Precautions, place appropriate mask on the patient before leaving the room. · Remove protective wear and 		

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S000606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on document review and staff interview, the hospital failed to monitor information about health and activities as</p>	S000606	<p>wash or decontaminate hands. If necessary, replace with clean non-sterile gloves or transfer to the designated area. Once transportation is complete, discard soiled linen per hospital policy and disinfect vehicle used for transfer with an appropriate germicidal. Follow hand hygiene procedure.</p> <p>ISDH PLAN OF CORRECTION</p> <p>STATE TAG ID: S0606</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 4/16/2014</p>	04/16/2014	

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	<p>they relate to diseases that are transmissible through food for 1 kitchen worker (staff member #F). Findings:1. Indiana Code 410 IAC 7-24-120 Sec 120. (a) states "The owner or operator of a retail food establishment shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food." 2. Staff member #F personnel file did not identify that the food service staff was provided information on how to report diseases that are transmittable through food. 3. Staff member #3 verified the above in interview beginning at 3:10 p.m. on 3/13/14.</p> <p>4. Staff members #N1, N4, N5, and N6 personnel files lacked evidence of disease history/immunity to Rubeola.5. Staff member #31 verified the above at 5:20 p.m. on 1/9/14.</p>		<p>WHAT IS THE PLAN OF CORRECTION: ALL EMPLOYEES WILL HAVE EVIDENCE OF DISEASE HISTORY/IMMUNITY TO RUBEOLLA, RUBELLA, AND VARICELLA.</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR: THE POLICY FOR EMPLOYEE EXAMINATION WAS REVIEWED/REVISED AND DETERMINED TO INCLUDE THE EMPLOYEE HISTORY/IMMUNITY TO BUBELLA, RUBEOLLA, AND VARICELLA. THE LABORATORY ORDER SET FOR NEW HIRE EMPLOYEES WAS CORRECTED TO INCLUDE THE RUBEOLLA TITER, WHICH HAD BEEN REMOVED (IN ERROR) BY A LAB EMPLOYEE WHO IS NO LONGER EMPLOYED BY SAINT CATHERINE REGIONAL HOSPITAL. ALL EMPLOYEE</p>		

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			<p>HEALTH RECORDS WERE REVIEWED TO ENSURE THEY INCLUDE HISTORY/IMMUNITY TO RUBELLA, RUBEOLLA, AND VARICELLA. ANY EMPLOYEE HEALTH RECORDS THAT DID NOT INCLUDE THIS INFORMATION WAS UPDATE ACCORDINGLY.</p> <p>WHO IS RESPONSIBLE: GINGER OTTERSBACK RN, CNO; KELLI BRASWELL RN, ER DIRECTOR AND EMPLOYEE HEALTH; CLARK DANIELS, LAB DIRECTOR; DOUG LEE, HR DIRECTOR; KIMMIE C PERRA RN, QUALITY DIRECTOR/NURSING EDUCATION/IP</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 4/16/2014</p> <p>HOW THE DEFICIENCY</p>		

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			<p>REOCCURRENCE WILL BE PREVENTED: ALL HUMAN RESOURCES, EMPLOYEE EDUCATION AND EMPLOYEE HEALTH FILES WILL BE FLAGGED OR IDENTIFIED AS INCOMPLETE UNTIL ALL REQUIRED FORMS ARE COMPLETED BEFORE THEY ARE PERMANENTLY FILED IN EACH DEPARTMENT.</p> <p>THE FOLLOWING IS A COPY OF THE</p> <p>POLICY REVIEWED/REVISED: 4/14 POLICY: To establish the criteria for obtaining physical examination information and/or any other medical examination data deemed necessary to determine an individual's ability to perform the essential job functions of each position within the organization.</p> <p>PROCEDURE: The company reserves the right to require employees to undergo medical examinations under the following circumstances:</p> <p>1. The company may require a candidate (post-offer) or employee to submit to a medical examination or ask disability-related questions only if such questions are "job-related and consistent with business necessity" means that the inquires or examinations must address actual problems with the employees actual performance of the job or legitimate concerns about whether the employee</p>		

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			<p>poses a direct threat in the position. Offers of employment will be rescinded if the employee does not satisfactorily pass the medical examination. The cost of such examination will be paid for in full by the employer. The post-offer employment exam will include the following (on forms attached as appendices to this policy):</p> <ul style="list-style-type: none"> · HISTORY to be completed by the applicant and PHYSICAL to be completed by the physician, Nurse Practitioner or Physician Assistant. · Healthcare Worker Screening Questionnaire to be completed by the applicant (which includes information on the Immunizations and titers, TB tests and exposures as well as Allergies and Sensitivities). · Lifting Ability Assessment to be completed by the Physician. · Blood work screenings including titers for immunizations · 2 Step PPD test or chest X-ray (in lieu of PPD) <p>1. Return-to-work after an employee has been on a leave of absence for their own disability or worker's compensation leave may be required and if so, must be job related and consistent with business necessity. The examinations or inquiries must be related to the actual medical condition that caused the leave of absence and the employee's ability to perform only the essential functions of the job. Employees are required to bring</p>		

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			<p>in a note from their own treating physician upon the end of leave of absence, which states that the employee is released to return to full duty work, however, the company reserves the right to have a medical examination performed by the physician of their own choosing. NOTE: July 2000 EEOC Guidance provides that the Employer must have a reasonable belief that the employee's ability to perform essential job functions will be impaired by the condition or will pose a direct threat to the employee or others. The cost for such exams will be paid for in full by the employer.</p> <p>2.Fitness for Duty exams must be job related and consistent with business necessity. Such exams will be requested when the employee is having difficulty performing the essential functions of the job. The company reserves the right to have such a medical examination performed by a physician of their choosing. NOTE: July 2000 EEOC Guidance provides that the Employer must have a reasonable belief that the employee's ability to perform essential job functions will be impaired by the condition or will pose a direct threat to the employee or others. The cost for such exams will be paid for in full by the employer.</p> <p>3.FMLA Second opinion exams may be required by the employer</p>		

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S000612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee</p>		<p>in cases where an employee requests a leave of absence under the Family Medical Leave Act and the employer questions the necessity for the leave. The right to require a second exam by the physician of the company's choice is a protected right under the FMLA regulations and the cost for such exams will be paid for in full by the employer.</p> <p>4. Physical Examination results (and medical information in general) are to be kept in the strictest confidence and maintained in files separate from the employee's personnel file. Only those with legitimate business reason may have access to medical information (including the Supervisor, Department Manager, Human Resources, and the Employee Health Nurse). Medical information must be kept confidential even if the candidate was not selected or if the employee is no longer employed by the company. Medical information on employees is required to be kept for 30 years post termination of employment.</p>		

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	<p>responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling.</p> <p>Based on observation, document review and interviews, the facility failed to ensure laundry services were provided according to facility policy and standard of practice for one (1) in-house laundry service. Findings include;1. The laundry room outside the BHU and utilized by BHU staff lacked a handwashing sink or hand sanitizer in the room. 2. CDC document titled "Guidelines for environmental infection control in healthcare facilities" states "Ensure that laundry areas have handwashing facilities and products and appropriate PPE available for workers..... Category IC (AIA: 7.23.D4; OSHA: 29 CFR 1910.1030 \c2\ a7 d.2.iii)"3. Facility policy titled "Patient Laundry" effective 3/14 indicates patient laundry will be washed separately and a disinfect cycle of bleach will be performed after each load of laundry. 4. Staff member #110 indicated the following in interviews that began at 1:40 p.m. on 3/12/14:(A) He/she does not use bleach between wash cycles when washing patient laundry. 5. Staff member #62 indicated the</p>	S000612	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S612 DATE DEFICIENCY WILL BE CORRECTED: 04/16/2014 WHO IS RESPONSIBLE: DAVE MILLET (FACILITIES DIRECTOR) GINGER OTTERSBAACH (CNO) WHAT IS THE PLAN OF CORRECTION: HANDWASHING SINK AND HAND SANITIZER DISPENSER IN THE LAUNDRY AREA ON BEHAVIORAL HEALTH UNIT EMPLOYEE EDUCATION ON BEHAVIORAL UNIT LAUNDRY POLICY AND PROCEDURES WHEN THE PLAN OF CORRECTION WILL BEGIN: 04/15/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: A HANDWASHING SINK WAS INSTALLED IN THE LAUNDRY AREA ON THE BEHAVIORAL UNIT, ALONG WITH A HAND SANITIZER DISPENSER, AND ALL PPE HAS BEEN MADE AVAILABLE IN THIS LAUNDRY AREA IN ORDER FOR EMPLOYEES TO USE STANDARD PRECAUTIONS WHILE</p>	04/16/2014

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	<p>following in interviews beginning at 1:40 p.m. on 3/12/14:(A) He/she thinks the detergent used has bleach in it and he/she wipes the inside of the washer/dryer with bleach after use. He/she has ran a bleach cycle "at times".</p> <p>7. Interview with the infection control nurse beginning at 1:00 p.m. on 1/8/14 indicated that he/she was unaware of any in-house laundry services provided by the facility.8. Staff member #20 indicated the following in interview beginning at 12:45 p.m. on 1/9/14: (A) There were no specific requirements for laundry on the unit. He/she indicated you could use hot or warm water and he/she used warm. 9. During tour of the behavioral health unit beginning at 11:45 a.m. on 1/9/14 and accompanied by staff members #1 and #N10, the following was observed:(A) The unit has a washer and dryer utilized for patient personal laundry.(B) Staff member #N10 indicated that the laundry was sorted and each patient's laundry is washed individually, however when asked who the laundry belonged to that was in the washer at the time of the tour, it was found that different articles of patients' laundry were in the washer. (C) Staff member #10 did not wear gloves to handle the soiled laundry in the laundry room which included laundry belonging to a patient with MRSA. (D) The laundry room contained a large box of powder detergent. Per label instructions, the detergent has no disinfectant properties.(E) There was no bleach or other disinfecting</p>		HANDLING PATIENT BELONGINGS. BEHAVIORAL HEALTH UNIT LAUNDERING POLICY WILL DEFINE POLICY AND PROCESS FOR LAUNDERING PATIENT'S CLOTHING USING SUN DETERGENT AND CHLORINE BLEACH. THIS POLICY WILL BE SUMMARIZED WITH AN INSTRUCTION SHEET POSTED IN THE BHS LAUNDRY ROOM WITH CLEAR INSTRUCTIONS ON THE PROCESS FOR LAUNDERING PATIENT CLOTHING INCLUDING: SUN DETERGENT AND CHLORINE BLEACH MANUFACTERER'S RECOMMENDED AMOUNT OF DETERGENT TO USE TO PROPERLY CLEAN THE CLOTHING SPECIFIC INSTRUCTIONS THAT EACH PATIENT'S CLOTHES ARE TO BE LAUNDERED INDIVIDUALLY INSTRUCTIONS FOR A BLEACH CYCLE TO BE RAN AFTER EACH PATIENT WASH LOAD TO PROPERLY DISINFECT THE WASHER BETWEEN LOADS, INCLUDING THE AMOUNT OF BLEACH TO USE INSTRUCTIONS FOR SIGNING A DAILY LOG THAT WILL DOCUMENTATION OF INCLUDE EACH PATIENT LOAD WASH ALONG WITH DOCUMENTATION OF EACH BLEACH CYCLE LOAD FOLLOWING EACH PATIENT LOAD INSTRUCTIONS ON PROPER PPE TO BE WORN		

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	agents within the laundry area.10. Facility policy titled "LAUNDRY ROOM" last reviewed/revised 4/23/13 lacks directions including, but not limited to, glove use when handling soiled linens, handling isolation laundry, appropriate water temperatures or use of disinfectant agents. The policy basically states the clothing is washed by following "manufacturers instructions" on the detergent, dried, folded and put away.		WHEN HANDLING A PATIENT'S SOILED CLOTHING THIS POLICY WAS DEVELOPED AND APPROVED BY INFECTION CONTROL COMMITTEE AND MONITORING OF THIS PROCEDURE WILL BE DONE BY MONTHLY TRACKING OF THE LAUNDERING AND WASHER DISINFECTING LOG TO ENSURE COMPLIANCE WITH EACH LOAD OF PATIENT LAUNDRY DONE. THE RESULTS OF THIS MONITORING WILL BE REPORTED TO INFECTION CONTROL COMMITTEE QUARTERLY TO EVALUATE METHOD, COMPLIANCE, AND FOR NECESSARY POLICY REVISIONS. ALL EMPLOYEES WERE INSERVICED ON THIS NEW LAUNDRY POLICY AND PROCEDURES FOR WASHER DISINFECTING, INCLUDING PROPER PPE TO BE WORN WHEN HANDLING SOILED OR WORN PATIENT CLOTHING. ALL EMPLOYEES SIGNED DOCUMENTATION THAT THEY RECEIVED THIS INSERVICE. LAUNDRY POLICY AND PROCEDURES WILL BE INCLUDED IN NURSING ANNUAL SKILLS DAY CHECK OFF STATIONS AND DOCUMENTATION THAT ALL NURSING STAFF HAS RECEIVED ANNUAL UPDATES ON THESE PROCEDURES WILL BE MAINTAINED WITH THE ANNUAL SKILLS DAY	

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S000930	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on document review and interviews, the facility failed to ensure a registered nurse evaluated the care provided to patients on the behavioral health unit (BHU) for 3 patients who had positioning belts applied that they could not remove and no orders for restraints. (patient #6, #7, and #8) Findings include; 1. Facility policy titled "PATIENT RIGHTS AND RESPONSIBILITIES" last reviewed/revised 6/13 states on page 1: ".....the patient right to.....Considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.....Remain free from seclusion or restraints of any form that are not medically necessary or are used as a</p>	S000930	<p>PACKET KEPT ON EACH NURSING STAFF MEMBER. SIGN IN SHEETS FOR ANNUAL SKILLS DAY WILL BE MAINTAINED AS DOCUMENTATION OF ATTENDANCE.</p> <p>ISDH PLAN OF CORRECTION STATE TAG ID: S930 DATE DEFICIENCY WILL BE CORRECTED: 04/25/2014 WHO IS RESPONSIBLE: GINGER OTTERSBACK, RN, CNO WHAT IS THE PLAN OF CORRECTION: DAILY CHART CHECK FOR PHYSICIAN ORDER ACCURACY WHEN THE PLAN OF CORRECTION WILL BEGIN: 04/25/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: POLICY FOR DAILY CHART CHECKS TO ENSURE ALL PHYSICIAN ORDERS ARE RECEIVED, NOTED AND CARRIED OUT IS IN PLACE TO ENSURE THAT ALL PHYSICIAN ORDERS ARE FOLLOWED. THIS AUDIT WILL BE DONE EVERY 24 HOURS ON ALL CHARTS. THIS POLICY WILL BE PRESENTED TO ALL NURSING STAFF BY READ</p>	04/17/2014

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	<p>means of coercion, discipline, convenience or retaliation by staff." 2. Staff member #10 indicated the following in interviews which began at 1:40 p.m. on 3/12/14: (A) There were patients on the unit a.m. of 3/12/14 with belts on (securing them in their chairs). The unit was instructed by staff member #4 to remove the belts and throw them away prior to ISDH tour to unit on 3/12/14.3. Staff member #110 indicated the following in interviews which began at 1:40 p.m. on 3/12/14:(A) Patients on the BHU had positioning belts with clips on them prior to ISDH visit on the unit a.m. of 3/12/14 and he/she was told to take the belts off and throw them away. He/she took four (4) belts off prior to ISDH tour of the unit and placed in the closet where the wheelchairs are kept. Three (3) of the patients (patients #6, 7, and 8) that had the positioning belts on could not remove the belts themselves.4. Staff member #62 indicated the following in interviews which began at 1:40 p.m. on 3/12/14:(A) A female voice told staff to take the belts off of the patients about 30 minutes before ISDH toured the unit this a.m.5. Staff member #140 indicated the following in interviews which began at 1:40 p.m. on 3/12/14:(A) He/she is aware of "maybe 6 patients" who had a positioning belt on this a.m. that they could not remove themselves and that staff removed prior to ISDH tour of unit.6. Staff member #172 indicated the following in interviews which began at 1:40 p.m. on 3/12/14: (A) Positioning belts are used on the patients on the unit that are combative and/or confused and they cannot take the belts off.7. Staff member #1 indicated the following in interview at 10:40 a.m. on 3/12/14:(A) The facility has no self releasing velcro belts in stock and do not use the clasp release belts.</p>		<p>AND SIGN EDUCATION METHOD AND WILL BE INCLUDED IN ANNUAL SKILLS DAY CHECK OFF STATIONS. DOCUMENTATION THAT ALL NURSING STAFF HAS RECEIVED ANNUAL UPDATES ON THIS CHART CHECK POLICY AND PROCEDURE WILL BE MAINTAINED WITH THE ANNUAL SKILLS DAY PACKET KEPT ON EACH NURSING STAFF MEMBER.</p>		

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in five (5) instances. Findings included: 1. General Department Safety Policy (Last approved April 23rd, 2013) indicated that each department shall maintain their department safe and sanitary to provide physical safety of patients, visitors, and employees. 2. At 10:30 a.m. on 3/12/14 and 8:30 a.m. on 3/13/14, the Main Entrance handicap doors were not operational.</p>	S001118	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S1118 DATE DEFICIENCY WILL BE CORRECTED: 4/23/2014 THE HANDICAP ACCESS DOOR IN THE MAIN ENTERANCE OF THE HOSPITAL WAS FIXED ON 4/16/14 WHO IS RESPONSIBLE: DAVE MILLET (FACILITIES MANAGEMENT) WHAT IS THE PLAN OF CORRECTION: REPAIR OF ALL STRUCTURAL AND COSMETIC DEFICIENCIES FOUND WITHIN THE FACILITY. UPDATING OF FACILITY PLANS REGARDING ENVIRONMENTAL INSPECTIONS, AND REVISIONS OF UTILITIES MANAGEMENT POLICIES. WHEN THE PLAN OF CORRECTION WILL BEGIN: 4/7/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: HEATING AND AIR CONDITIONING UNIT REPLACEMENT IN ROOMS 316</p>	04/23/2014	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			AND 317 BEGAN ON 4/7/2014 AND WAS COMPLETED ON 4/9/2014. THE DRYWALL, BASEBOARD, HAND RAIL AND WALL COSMETIC REPAIRS BEGAN ON 4/7/2014 AND WILL BE COMPLETED ON 4/23/2014. ROOF REPLACEMENT WAS BEGAN ON 4/16/2014 AND WILL BE COMPLETED ON 4/26/2014. CEILING TILE REPLACEMENT BEGAN ON 4/7/2014. ALL STAINED TILES WERE REPLACED. ANY STAINS FOUND AFTER 4/26/2014 WILL BE REPLACED FOLLOWING THE COMPLETION OF THE ROOF REPLACEMENT ON 4/26/2014. THE ENVIRONMENTAL TOURS WERE REINSTATED ON 4/14/2014 USING A PRE ESTABLISHED INSPECTION CHECKLIST AND WILL BE COMPLETED ON A MONTHLY BASIS. DOCUMENTATION OF THESE TOURS WILL BE MAINTAINED IN THE OFFICE OF THE FACILITIES MANAGEMENT. UTILITIES MANAGEMENT POLICY AND PROCEDURE MANUAL WAS REVIEWED AND/OR REVISED ON 3/18/14.	